5. **Physician Services (Continued)**

1997 REIMBURSEMENT RATES
PEDIATRIC PRACTITIONER SERVICES (Continued)

	Counseling and/or Risk Factor Reduction Intervention - New or Established Patient (Continued)	**PRICE**
	Preventive Medicine, Group Counseling	
99411	Counseling and/or risk factor reduction intervention(s) provided to healthy individuals in a group setting; approximately 30 minutes	N.C.
99412	Approximately 60 minutes	N.C.
	Other Preventive Medicine Services	
99420	Administration and interpretation of health risk assessment instrument (e.g., health hazard appraisal)	N.C.
99429	Unlisted preventive medicine service	N.C.
	Newborn Care	
99432	Normal newborn care in other than hospital or birthing room setting, including physical examination of baby and conference(s) with parent(s)	47.48
	Immunizations	
90700	DTAP	*
90701	Immunization, active; diphtheria and tetanus toxoids and pertussis vaccine (DTP)	*
90702	Diphtheria and tetanus toxoids (DT)	*
90703	Tetanus toxoid	*

5. **Physician Services (Continued)**

1997 REIMBURSEMENT RATES
PEDIATRIC PRACTITIONER SERVICES (Continued)

Immunizations		PRICE
90704	Mumps virus vaccine, live	*
90705	Measles virus vaccine, live	*
90706	Rubella virus vaccine, live	*
90707	Measles, mumps and rubella virus vaccine, live	*
90708	Measles and rubella virus vaccine, live	
90709	Rubella and mumps virus vaccine, live	*
90710	MMR and varicella vaccine	B.R.
90711	DTP and injectable poliomyelitis vaccine	B.R.
90712	Poliovirus vaccine, live, oral (any type(s))	*
90713	Poliomyelitis vaccine	*
90714	Typhoid vaccine	2.68
90716	Varicella vaccine	*
90717	Yellow fever vaccine	N.C.
90719	Diphtheria toxoid	N.C.
90720	DTP/HIB	*
90721	DTP/HIB VACCINE	N.C.
90724	Influenza virus vaccine	*
90725	Cholera vaccine	4.04

5. **Physician Services (Continued)**

1997 REIMBURSEMENT RATES
PEDIATRIC PRACTITIONER SERVICES (Continued)

Immunizations			PRICE
90726	Rabies vaccine		111.69
90727	Plague vaccine		N.C.
90728	BGC vaccine		4.54
90730	Hepatitis A vaccine		B.R.
90732	Pneumococcal vaccine, polyvalent		9.13
90733	Meningococcal polysaccharide vaccine (any group(s))		B.R.
90737	Hemophilus influenza B		*
90741	Immunization, passive; immune serum globulin, human (ISG)		WE USE "J" CODES 4.55 TO 17.60
90742	Specific hyperimmune serum globulin (e.g., hepatitis B, measles, pertussis, rabies, Rho(D), tetanus, vaccinia, varicella-zoster)		N.C.
	X0726	Rabies	60.25
	X0731	Hepatitis B hyperimmune	27.00
	X0743	Varicella-zoster 5	87.07
	X0742	Other specific hyperimmune globulin	B.R.

5. **Physician Services (Continued)**

1997 REIMBURSEMENT RATES
PEDIATRIC PRACTITIONER SERVICES (Continued)

Immunizations		PRICE
90744	Hepatitis B Vaccine, under 11	*
90745	Hepatitis B Vaccine, 11 - 18	*
90749	Unlisted Immunization Procedure	B.R.

* These immunizations are provided free to Medicaid providers for administration to Medicaid recipients. Additionally, providers are reimbursed $5.00.

6. Medical care and any other types of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

a. Podiatrist Services

Payment is based on the lesser of the billed charge or the Medicaid maximum for the particular service performed according to the department's procedure code reference file.

b. Optometrist Service

Payment is based on the lesser of the billed charge or the Medicaid maximum for the particular service performed according to the department's procedure code reference file.

c. Chiropractic Services

Payment is based on the lesser of the billed charge or the Medicaid maximum for the particular service performed according to the department's procedure code reference file.

d. Mechanotherapist Services

The payment is based on the lesser of the billed charge or the Medicaid maximum for the particular service performed according to the department's procedure code reference file.

e. Psychologist

The payment is based on the lesser of the billed charge or the Medicaid maximum for the particular service performed according to the department's procedure code reference file.

7. Home Health Care Services

a. Intermittent or part-time nursing service.

The payment is based on the lesser of the billed charge or the Medicaid maximum for the particular service performed according to the department's procedure code reference file.

b. Home Health Aide Services

The payment is based on the lesser of the billed charge or the Medicaid maximum for the particular service performed according to the department's procedure code reference file.

c. Medical supplies, equipment, and appliances for the patient's use in his own home.

The payment is based on the lesser of the billed charge, the Medicaid maximum according to the department's procedure code reference file, or, where no Medicaid maximum is specified, 75 percent of the average recommended list price for the particular service provided.

d. Physical therapy, occupational therapy and speech and hearing therapy services.

The payment is based on the lesser of the billed charge or the Medicaid maximum for the particular service performed according to the department's procedure code reference file.

STATE OF OHIO

ATTACHMENT 4.19-B
REFERENCE PRE-PRINT PAGE 3a
OF ATTACHMENT 3.1-A
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8. Private Duty Nursing Services.

REIMBURSEMENT FOR PRIVATE DUTY AND GROUP NURSING SERVICES is based on the lesser of the billed charge or the Medicaid maximum FEE for the particular service performed according to the department's procedure code reference file.

TN No. 93-23 APPROVAL DATE 10-15-93
SUPERSEDES
TN No. 90-38 EFFECTIVE DATE 7-30-93

9. Clinic Services

a. Ambulatory Health Care Centers

Payment is made on the basis of customary and reasonable charges up to the department's maximum for the particular service rendered. In no instance may the payment exceed Medicare reimbursement for the same service.

b. Outpatient Health Facilities

1. Payment for authorized services in an OHF is calculated on a prospective reasonable cost-related basis from cost reports filed by each participating clinic. Rates are calculated on a clinic's cost of allowable items and services, and thus may vary from clinic to clinic, subject to the tests of reasonableness described in paragraphs (4) to (8). While payments under a prospective system are not subject to audit and retroactive settlement or adjustment, the historical costs upon which prospective rates are based are audited. Adjustments to the paid rate will be made if costs are found to be overstated or misrepresented in a manner which resulted in an overstatement of the previously determined prospective rate (see paragraph (11). Retroactive adjustments may also occur to reconcile payments made to new facilities on the basis of an interim rate as provides in paragraph (3) or in accordance with paragraph (1)(b).

a. Rates will be established for each of the following types of services rendered by a participating OHF:

(i) medical services

(ii) laboratory services

(iii) radiological services

(iv) dental services

(v) speech therapy and audiology services

(vi) mental health services

(vii) physical therapy services

(viii) transportation services

(xi) vision care services

9. Clinic Services (Continued)

(b) Cost of items which were not requirements during the period covered by the base line cost report but which became requirements or were imposed by federal court orders during the prospective rate year are met on a retroactive basis based on cost reports filed at the conclusion of the prospective year. Only those expenses associated with the new requirements, which require the addition of new personnel or equipment, are subject to the one-time retroactive settlement. Thereafter, such costs become recognized according to the methodology described above.

2. For purposes of this paragraph, the "initial program year" is defined as the time period beginning with the effective date and ending December 31, 1983. Rates will be determined based on cost reports submitted for the period beginning January 1, 1982 and ending June 30, 1982, for the initial program year. Rates will be updated by an inflation factor as described in paragraph (9). Rates so established may be used by OHFs in billing for services provided on and after the effective date of the OHF provider agreement.

All OHFs must submit a cost report by October 3, 1983, for the period beginning July 1, 1982 through June 30, 1983. Rates will be established within 45 days of the date upon which a complete cost report is submitted. Rates so established will be used by OHFs in billing for services beginning January 1, 1984. Beginning April 1984 OHFs must adhere to instructions defined in paragraph (10) for cost report filing.

3. Except as noted in paragraph (2), interim rates for new facilities will be computed as follows: interim payments will be granted based on the average rates of all participating OHFs. Ongoing rates will be calculated from a cost report filed after one complete calendar quarter of experience. Ongoing rates will be computed according to the criteria set forth in paragraphs (4) to (8) (with no inflationary allowance) and will be adjusted to compensate for any overpayment/underpayment made during the interim period. For purposes of reimbursement provisions contained in this paragraph, a "new facility" is defined as any of the following:

9. Clinic Services (Continued)

a. A facility not participating in the Medicaid program for one year prior to OHF application.

b. A facility participating in Medicaid immediately prior to OHF application and expanding or adding services in order to meet the OHF requirements set forth in rule 5101:3-29-01 of the Administrative Code.

c. A facility approved as an OHF which undergoes a change of ownership due to purchase or lease (rental) by an unrelated party. Reference paragraph (4)(c) for definition of a related party.

d. A facility approved as an OHF which adds a service eligible for payment on a prospective rate basis.

4. "Cost which are reasonable and related to patient care" are those contained in the following reference material in the following priority: "Health Insurance Manual 15 Provider Reimbursement Manual," "Health Insurance Manual 5 Principles of Reimbursement for Provider Costs," and "General Accepted Accounting Principles"; except that:

a. Costs related to patient care and services that are not covered under the OHF program as described in rule 5101:3-29-01 to 5101:3-29-04 of the Administrative Code are not allowable.

b. The straight line method of computing depreciation is required for cost filing purposes, and it must be used for all depreciable assets.

c. For purposes of determining allowable and reasonable cost in the purchase of goods and services from a related party, the following definition of related shall be used: "Related" is one who enjoys, or has enjoyed within the previous five years, any degree of another business relationship with the owner or operator of the facility, directly or indirectly, or one who is related by marriage or birth to the owner or operator of the facility.